TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name
Orthopaedic Specialists of Austin

Respondent Name
Indemnity Insurance Company of North America

MFDR Tracking Number
M4-25-3165-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
August 1, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 17, 2025	CPT Code 99204	$418.47	$360.09

Requester's Position

"Gallagher Bassett is denying payment for CPI code 99204 [Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.] due to 'Based on the Documentation Submitted it is Recommended that Service Should be Lowered 1 Level'. It is our position that this denial is incorrect and payment is overdue."

Amount in Dispute: $418.47

Respondent's Position

"The carrier's position is that the provider is not entitled to reimbursement for CPT code 99204. The provider's documentation does not support the level of service billed by the provider."

Response Submitted by: Flahive, Ogden & Latson

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.305 sets out the procedures for resolving medical disputes.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 TAC §134.203 sets out the fee guideline for professional medical services.
4. 28 TAC §134.600 sets out the preauthorization guidelines for specific treatments and services.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- 150 - Payer deems the information submitted does not support this level of service.
- 16 - Claim/service lacks information or has submission/billing error(s).
- 197 - Precertification/authorization/notification/pre-treatment absent.
- M127 - Missing patient medical record for this service.
- MA27 - Missing/incomplete/invalid entitlement number or name shown on the claim.
- MA30 - Missing/incomplete/invalid type of bill.
- N179 - Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.
- P12 - Workers' compensation jurisdictional fee schedule adjustment.
- XXG15 - Pricing is calculated based on the medical professional fee schedule value.
- XXQC5 - Lacking risk
- XXQC9 - Based on the documentation submitted it is recommended that service should be lowered 1 level.
- XXUOO - There was no UR procedure/treatment request received.
- 00663 - Reimbursement has been calculated based on the state guidelines.
- 93 - No claim level adjustment
- N45 - Payment based on authorized amount.
- P13 - Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable.
- TX350 - Bill has been identified as a request for reconsideration or appeal.

- TX790 - This charge was reimbursed in accordance to the Texas medical fee guideline.
- W3 - In accordance with TDI-DWC RULE 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. Is the insurance carrier's denial based on the lack of precertification, authorization, notification, or pre-treatment approval supported?
2. Is the insurance carrier's denial based on the determination that the submitted information does not justify the level of service provided, and the recommendation to reduce the service level by one level based on the documentation supported?
3. Is the requester entitled to reimbursement?

Findings

1. This dispute pertains to a reduction of payment for an evaluation and management service rendered on February 17, 2025, and billed under CPT code 99204. The carrier denied reimbursement under denial code "197 - Precertification/authorization/notification/pre-treatment absent".

   28 Texas Administrative Code §134.600(p)(12) states, in relevant part, that non-emergency health care requiring preauthorization includes treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not included in a treatment plan preauthorized by the insurance carrier."

   A review of the Division of Workers' Compensation Disability Management Questions and Answers document, updated on May 21, 2020, clarifies that office visits do not require preauthorization but remain subject to retrospective utilization review for medical necessity. Although the Official Disability Guidelines (ODG) recommend office visits within procedure summaries, there is no established limit on the number of medically necessary office visits.

   Based on this, the Division concludes that the insurance carrier's denial reason "197" is unsupported. Therefore, the requester is entitled to reimbursement for the disputed service.

2. The carrier also denied reimbursement under denial codes "150 - Payer deems the information submitted does not support this level of service" and "XXQC9 - Based on the documentation submitted it is recommended that service should be lowered 1 level"

   28 TAC §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   28 TAC §134.203(b)(1) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and

physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

The requester billed CPT code 99204 defined as "Office or other outpatient visits for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter."

- The American Medical Association (AMA) CPT Code and Guideline Changes, effective January 1, 2021, can be found at: https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf. In summary, CPT 99204 documentation must contain two out of three of the following elements: 1) moderate level of number and complexity of problems addressed 2) moderate level of amount and/or complexity of data to be reviewed and analyzed 3) moderate risk of morbidity/mortality of patient management OR must document 45-59 minutes of total time spent on the date of patient encounter.
- An interactive E&M scoresheet tool is available at: https://www.novitas-solutions.com/webcenter/portal/MedicareJL/EMScoreSheet
- A review of submitted medical documentation finds that a moderate level of MDM was met in the elements of 1) number and complexity of problems addressed 2) moderate level of amount and/or complexity of data to be reviewed and analyzed. Submitted medical record shows no documentation of time spent on date of encounter. For these reasons, medical documentation submitted did meet AMA criteria for reimbursement of CPT code 99204.

The division finds that the requester is entitled to reimbursement for CPT code 99204 rendered on February 17, 2025.

3. 28 TAC §134.203(c)(1) states, "…To determine to MAR for professional services, system participants shall apply the Medicare payment policies with minimal modification…For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $53.68…"

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

   - The 2025 DWC Conversion Factor is 70.18
   - The 2025 Medicare Conversion Factor is 32.3465
   - A review of the medical bills finds that the disputed services were rendered in zip code 78751; the locality is "Austin."
   - The Medicare Participating amount for CPT code 99204 at this locality is $165.97.
   - Using the above formula, the DWC finds the MAR is $360.09.
   - The respondent paid $0.00.
   - The requester seeks $418.47.

- Reimbursement of $360.09 is recommended for date of service February 17, 2025.

The DWC finds that the requester is entitled to reimbursement for the disputed services. As a result, $360.09 is due

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requester and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

The DWC finds the requester has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to reimbursement for the disputed services. It is ordered that the respondent must remit to the requester $360.09 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		September 11, 2025
Signature	Medical Fee Dispute Resolution Officer	Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.